3 Physician Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by physicians as deemed appropriate by the Department of Health and Welfare. It addresses the following:

- General physician policy.
- Medical policy restrictions.
- Medical/surgical review.
- Specific medical services.
- Prior authorization (PA).
- Claims billing.

3.1.2 Reimbursement

Idaho Medicaid reimburses physician services on a fee-for-service basis. Medicaid reimbursement will be either the lowest of the provider's actual charge for the service or Medicaid's established maximum allowable reimbursement from its pricing file, minus the payment from Medicare or other insurance.

Site of Service Differential: The Centers for Medicare and Medicaid Services (CMS) physician fee schedule indicates which procedure codes can be completed in an office setting. For these codes there is a site-of-service differential, which is an average of 30 percent reduction of the Idaho Medicaid fee schedule, if completed in a facility setting, *e.g.*, hospital or surgery center versus an office setting.

Physician services must be billed by the physician provider electronically or on the CMS-1500 claim form using the appropriate procedure codes.

Note: Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral from the participant's primary care physician (PCP) must be obtained prior to rendering services.

3.1.3 Procedure Codes

Idaho Medicaid follows national procedure codes as listed in the most current version of:

- Current Procedural Terminology (CPT).
- Healthcare Common Procedure Coding System (HCPCS).
- International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM).

If a non-specific procedure code is used and the Medicaid medical consultant determines a listed procedure code exists that accurately describes the procedure performed, the claim may be denied.

3.1.4 Place-of-Service (POS) Codes

Idaho Medicaid follows national POS codes. Refer to *Current Procedural Terminology (CPT) Manual.* Enter the appropriate numeric code in the place of service field on the claim.

3.1.5 Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Access to care:

The intent of this program is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

3.1.6 Physician Service Policy

3.1.6.1 Overview

All physicians licensed to practice medicine in any state, are eligible to participate in the Idaho Medicaid Program. They must enroll as an Idaho Medicaid provider with EDS prior to submitting claims for services.

See *Section 1.2 Services for Providers,* for more information on enrolling as an Idaho Medicaid provider.

3.1.6.2 Physician Employees

Services provided by employees of a physician may not be billed directly to Idaho Medicaid with the exception of psychological testing services provided by a licensed psychologist or social worker. These testing services provided by physician employees may be billed under the physician's provider number. This exception applies to testing only.

3.1.6.3 Misrepresentation of Services

Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other non-physician professional was rendered as a physician service is prohibited.

3.1.6.4 Out-of-State Care

Out-of-state providers who are enrolled in the Idaho Medicaid Program and have an active Idaho Medicaid provider number may render services to Idaho Medicaid participants without receiving out-of-state prior approval.

All medical care provided outside the state of Idaho is subject to the same utilization review, coverage requirements, and restrictions as medical care provided within Idaho. See *Section 3.3 Medical/Surgical Review*, for more information.

3.1.6.5 Locum Tenens and Reciprocal Billing

Idaho Medicaid allows for physicians to bill for Locum Tenens and Reciprocal Billing.

Definition of Locum Tenens and Reciprocal Billing: The practice for physicians to retain substitute physicians to take over their professional practices when the regular physician(s) is absent for reasons such as: illness, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though they performed them.

Duration of Locum Tenens: Locum Tenens occurs when the substitute physician covers the regular physician during absences not to exceed a period of 90 continuous days.

Duration of Reciprocal Billing: Reciprocal billing occurs when the substitute physician covers the regular physician during absences or on an on call basis not to exceed a period of 14 continuous days.

Requirements and Procedures for Billing:

- The regular physician is unavailable to provide the services.
- The Medicaid participant has arranged or seeks to receive services from the regular physician.
- The regular physician pays the locum tenens for their services on a per diem, or similar fee-for-time basis.
- The substitute physician does not provide the services to Medicaid participants over a continuous period of longer than 90 days for locum tenens and 14 days for reciprocal billing.
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by appending the appropriate modifier to the procedure code.

  Q6 Service furnished by a locum tenens physician.

  Q5 Service furnished by a substitute physician under a reciprocal billing arrangement.
- The regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's National Provider Identifier (NPI) , and make this record available to DHW upon request.
- If the only substitution services a physician performs are in connection with an operation and are post-operative services furnished during the period covered by the global fee, those services should not be reported separately on the claim as substitute services.
- A physician may have locum tenens/reciprocal billing arrangements with more than one physician. The arrangements do not need to be in writing.

3.2 Medical Policy Restrictions

3.2.1 Examinations

3.2.1.1 Wellness Physicals - Adults 21 Years of Age and Over:

- Adult preventive medicine procedures will be limited to one per rolling year.
- Evaluation and management procedures will not be paid on the same day as a preventive medicine procedure for participants over age 21.
- Preventive medicine procedures billed for participants over age 21 must be billed with a diagnosis code of **V70.0**, **V72.3**, **V72.31**, or **V72.32**, or the claim will be denied.
- Bill the appropriate procedure code for the participant's age as listed in the *Current Procedural Terminology (CPT) Manual* (see below):

99385 New patient preventive medicine examination; Adult age 18 – 39.

99386 New patient preventive medicine examination; Adult age 40 – 64.

99387 New patient preventive medicine examination; Adult age 65+.

99395 Established patient preventive medicine examination; Adult age 18 – 39.

99396 Established patient preventive medicine examination; Adult age 40 – 64.

99397 Established patient preventive medicine examination; Adult age 65+.

A health risk assessment/preventive physical examination for an adult that is a requirement of Idaho Medicaid is a covered service. When an exam and/or report is required by Department of Health and Welfare (DHW) for an adult participant, including annual history and physical exams for adults living in an Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR) Facility, use one of the following two CPT codes with the ICD-9 primary diagnosis code **V70.3**:

99450 Basic life and/or disability examination that includes: History, physical, and completion of necessary documentation.

99080 Special reports, more than the information conveyed in the usual medical communications or standard reporting form. This code should be used when the provider can complete the DHW required history and physical information from past records rather than a new examination.

Note: Special reports and pre-employment physicals for individuals age 21 and older are not covered by Idaho Medicaid.

3.2.1.2 Wellness Physicals for Children up to the Age of 21

Health risk assessment physicals for children are covered based on the early and periodic screening, diagnosis, and treatment (EPSDT) periodicity requirements. See *Section 1 General Provider & Participant Information, subsection 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).*

http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=569&MId=10826&wversion=Staging

Routine physicals such as pre-school, school, summer camp, Special Olympics, or sports examinations for individuals up to the age of 21 are covered with diagnosis **V70.3** as long as one of the above reasons is listed on the claim form. The provider must use the preventive medicine procedure codes and diagnosis code **V20.1** or **V20.2** when billing for wellness physical exams.

3.2.2 Elective Treatment

Prior authorization (PA) is required for all elective medical and surgical procedures. Procedures generally accepted by the medical community as medically necessary may not require PA and may be eligible for payment. (Medicaid medical necessity criteria for some procedures are listed in this handbook.)

3.2.3 Injectable Vitamins

Payment for injectable vitamin therapy must be supported by the diagnosis of pernicious anemia. Injectable vitamin therapy is limited to the following:

- Vitamin B_{12} and its analogues.
- Vitamin K and its analogues.
- Folic acid.
- Vitamin B_{12} mixtures, folic acid, and iron salts in any combination.

3.2.4 Transplants

3.2.4.1 Overview

Department of Health and Welfare may purchase organ transplant services for bone marrow, kidneys, hearts, intestines, and livers when:

- It is provided by a hospital approved by Centers for Medicare and Medicaid Services (CMS) for Medicare transplants.
- That facility has completed a provider agreement with DHW.
- The transplant has a PA by the Idaho Quality Improvement Organization (QIO).

Department of Health and Welfare may purchase cornea transplants for conditions where such transplants have demonstrated efficacy. Cornea transplants do not require QIO PA.

3.2.4.2 Heart or Liver Transplants

Heart or liver transplant surgery will be covered only if the procedure is performed in a transplant facility approved for transplant of the heart or liver by CMS for the Medicare Program and the provider has completed a provider agreement with DHW.

3.2.4.3 Kidney Transplants

Kidney transplantation surgery will be covered only in a renal transplantation facility participating in the Medicare Program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one of the End Stage Renal Dialysis (ESRD) network of Health and Human Services for Medicare certification.

3.2.4.3.1 Living Kidney Donor Costs

The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post operation recovery expenses associated with the donation. Payments for post operation expenses of a donor will be limited to the period of actual recovery.

3.2.4.4 Coverage Limitations

When the need for transplant of a second organ such as a heart, lung, liver, bone marrow, pancreas, or kidney represents the coexistence of significant disease, the organ transplants will not be covered.

If medically necessary, otherwise non-covered transplants may be prior authorized through EPSDT for children under the age 21.

Each kidney or lung is considered a single organ for transplant.

3.2.4.5 Re-Transplants

Re-transplants will be covered only if the original transplant was performed for a covered condition and if the re-transplant is performed in a Medicare/Medicaid approved facility.

3.2.4.6 Multi-Organ Transplants

Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered unless it is for an EPSDT participant, it is medically necessary, and is prior authorized.

3.2.4.7 Transplant Authorization

Except for cornea transplants, all organ transplants are excluded from Medicaid payment unless a PA is obtained through the QIO and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy.

3.2.4.8 Non-Covered Transplants

Services, supplies, medications, transportation, or equipment directly related to a non-covered transplant will not be covered by Medicaid.

3.2.4.9 Follow-Up Care

Follow-up care to a participant who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation.

3.2.5 Limitations

3.2.5.1 Cosmetic Surgery

All surgery which is generally cosmetic in nature is excluded from payment unless it is found to be medically necessary and is prior authorized.

3.2.5.2 Bariatric Surgery

Medicaid will only cover bariatric surgeries that are performed in a Medicare-approved bariatric surgery center (BSC) or bariatric surgery center of excellence (BSCE). A list of facilities approved by Medicare for bariatric surgery is available online from the CMS Web site at: ***http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage***.

Any surgery for the correction of obesity is covered only if PA is given by Qualis Health and with final approval by the Division of Medicaid. If approval is granted, Qualis Health will issue the authorization number and conduct a length-of-stay review.

All participants must meet the criteria for morbid obesity as defined in *Medicaid Basic Plan Benefits*, *IDAPA 16.03.09.431 Surgical Procedures for Weight Loss-Participant Eligibility, through IDAPA 16.03.09.434, Surgical Procedures for Weight Loss - Provider Qualifications and Duties* including:

The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than 40.

BMI equal to or greater than 35 with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities.

The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery.

The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory, or other systemic disease.

The participant must have a psychiatric evaluation to determine the stability of personality at least 90 days prior to the date a request for PA is submitted to Medicaid.

Administrative rules specific to Medicaid coverage for bariatric surgery are found in IDAPA 16.03.09.431 Surgical Procedures for Weight Loss-Participant Eligibility, through IDAPA 16.03.09.434, Surgical Procedures for Weight Loss - Provider Qualifications and Duties, available online at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf**.

3.2.5.3 Abdominoplasty or Panniculectomy

Abdominoplasty or panniculectomy is covered only with PA from Qualis Health. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for PA includes, but is not limited to, the following:

- Photographs of the front, side, and underside of the participant's abdomen.
- Documented treatment of the ulceration and skin infections involving the panniculus.
- Documented failure of conservative treatment, including weight loss.
- Documentation that the panniculus severely inhibits the participant's walking.
- Documentation that the participant is unable to wear a garment to hold the panniculus up.
- Documentation of other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body.

3.2.5.4 Unproven/Questionable Procedures

New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and which are excluded by the Medicare Program are excluded from payment by Medicaid.

3.2.5.5 Complications

The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment if the resultant condition is determined by Medicaid to be life threatening.

3.2.5.6 Acupuncture

Acupuncture is not covered.

3.2.5.7 Naturopathic Services

Naturopathic services are not covered.

3.2.5.8 Biofeedback Therapy

Biofeedback therapy is not covered.

3.2.5.9 Fertility Related Services

Fertility-related services, including testing, are not covered.

3.2.5.10 Laetrile Therapy

Laetrile therapy is not covered.

3.2.6 Oral Surgeons

Oral surgeons who perform services in the hospital setting are required to bill CPT surgical codes on the CMS-1500 claim form using their physician provider number.

Do not use CPT procedure code **41899**, as this is an unspecified code and will cause delay in payment for services.

Extractions must be billed on an ADA claim form under the provider's dental provider number, with the appropriate common dental terminology dental code and tooth number.

Note: Do not bill on a CMS-1500 claim form for extractions.

3.3 Medical/Surgical Review

3.3.1 Overview

Medicaid contracts with a Quality Improvement Organization (QIO), formerly called a Peer Review Organization, to conduct review on a preadmission basis for selected diagnoses and procedures and a concurrent length of stay review on all hospital stays that exceed a specified number of days.

All inpatient admissions must be reviewed with Department of Health and Welfare (DHW) QIO if the stay exceeds three days, except for cesarean delivery (admitting or principal diagnosis) which needs review if the stay exceeds four days. If after a three day stay, the patient is not discharged by the next day (count the day of the admission as day one); a review must be obtained on or before day four, and thereafter at intervals determined by the QIO. If the re-certification date falls on a weekend or holiday, follow the procedures detailed in the *Qualis Health Provider Manual Section XVII* at: **http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm** or contact Qualis Health for detailed instructions.

Children in legal guardianship or legal custody of DHW are also subject to QIO review on a pre-admission basis and concurrent review for all hospital stays using the same criteria as for Medicaid participants.

Quality Improvement Organization conducts 100 percent pre-admission and concurrent review of all admissions to inpatient psychiatric facilities for Idaho Medicaid participants.

Note: Medicaid Basic Plan participants are limited to ten days of inpatient mental health services per year.

Quality Improvement Organization performs retrospective reviews for services that were not reviewed in a timely manner (penalties may apply). Retrospective reviews may also be requested from the QIO for services requiring prior authorization (PA) and for admissions longer than three days when the patient receives retroactive eligibility. Refer to the *Qualis Health Provider Manual, Section XV*, for instructions at: **http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm**.

The participant's physician or the treating facility may initiate the request for PA. Both providers are equally responsible for obtaining authorization.

3.3.2 Penalties

Medicaid assesses a penalty to physicians and hospitals for failure to obtain a timely QIO review instead of withholding total payment. Information on the penalty amounts are detailed in the *Medicaid Basic Plan Benefits, IDAPA 16.03.09.505 Physician Services - Provider Reimbursement* and *IDAPA 16.03.09.705.03 Inpatient Psychiatric Hospital Services - Provider Reimbursement; Physician Penalty Schedule*. These rules are available online at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf** or by calling the Department of Administration, Office of Administrative Rules at: **(208) 332-1822**.

3.3.3 Prior Authorization (PA)

3.3.3.1 Prior Authorization (PA) Notification

If a service is approved, a PA number is given to the provider requesting the approval either by a Notice of Decision for Medical Services letter from Medicaid, or telephonically from Qualis Health. The PA number must appear in the appropriate field on the physician, hospital and, if applicable, assistant surgeon and anesthesiologist claim forms. It is not necessary to attach a copy of the PA letter to a claim form. When billing electronically, more than one PA number is allowed on the claim. PA numbers can be entered at both the header and detail level. Enter the PA number associated to the service detail in the appropriate field on the screen.

Note: Providers billing services that require PA on a paper form can only bill one authorization number per claim and the PA number must be indicated on the claim.

Lists of diagnosis and procedure codes that require PA are found in *Sections 3.3.3.5 Quality Improvement Organization (QIO) Diagnosis Codes, 3.3.3.6 Quality Improvement Organization (QIO) Procedure Codes*, and *3.3.3.7 Prior Authorization (PA).*

See *Section 2.3 Prior Authorization (PA)*, for more information on electronically billed services that require PA.

3.3.3.2 Third Party Recovery (TPR)

A participant who is a Medicare/Medicaid participant will only need to have PA from the primary carrier, Medicare. Participants who have any other third party coverage, such as a private insurance company, private individual, corporation, or business, must still obtain PA from Qualis Health or Medicaid.

3.3.3.3 Healthy Connections (HC)

Healthy Connections participants require a referral from their primary care provider (PCP) for all inpatient and outpatient hospital services in addition to a Medicaid or Qualis Health PA.

3.3.3.4 Quality Improvement Organization (QIO) Contact Information

To obtain a Qualis Health provider manual or for additional information regarding the review process, contact Qualis Health at:

Qualis Health
PO Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400
(800) 783-9207 (toll free)
Fax: (800) 826-3836
http://www.qualishealth.org/cm/idaho-medicaid

Provider representatives are available Monday through Friday from 7:30 a.m. - 6:45 p.m. MT and 6:30 a.m. - 5:45 p.m. PT (excluding state holidays).

3.3.3.5 Quality Improvement Organization (QIO) Diagnosis Codes

Inpatient diagnoses requiring PA for Idaho Medicaid and Division of Family and Children's Services (FACS) participants are:

Diagnosis Requiring Prior Authorization (PA)
Inpatient Psychiatric or Chemical Dependency Admissions (use fourth or fifth digit sub-classification): **291.0** - **314.9**
Inpatient Physical Rehabilitation Admissions: **V57.0** - **V57.9** **Note:** This includes admission to all rehabilitation hospitals, regardless of the diagnosis on the claim.

3.3.3.6 Quality Improvement Organization (QIO) Procedure Codes

All surgical procedures on the following list require pre-authorization for inpatient and outpatient services. For more information please call at: **(800) 783-9207** or fax at: **(800) 826-3836**.

The select PA list is also available on the Quails Web site at: **http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm**.

Procedure	ICD-9-CM Code	CPT® Code
Arthrodesis (Spinal Fusion) **Note:** Artificial disc not a covered benefit.	78.59 81.00 through 81.08 81.30 through 81.39	22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849,

Procedure	ICD-9-CM Code	CPT® Code
Unlisted neck, thorax procedure Unlisted spine procedure	81.62, 81.63, 81.64 78.41 78.71	22851, 27280 21899 22899
Laminectomy/Diskectomy Laminoplasty	03.02 03.09 03.1 03.6 80.50 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195,63196, 63197, 63198, 63199, 63200
Hysterectomy Abdominal Vaginal Laparoscopic Radical Other and Unspecified	57.84, 65.61 68.31, 68.39, 68.41, 68.49, 68.61, 68.69 68.51 68.59 68.71, 68.79 68.9	51925, 58956, 58180, 58953, 58954, 59135, 59525 58150, 58152, 58200, 58951, 59135, 59525 58210 58550, 58260, 58262, 58263, 58267, 58270, 58552, 58553, 58554 58275, 58280, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58548 58570, 58571, 58572, 58573 58285
Reduction Mammoplasty Unilateral, Bilateral	85.31, 85.32	19318
Total Hip Replacement Revision	81.51 81.53 00.70–00.76, 00.77, 00.85, 00.86, 00.87	27130 27132, 27134, 27137, 27138
Partial Hip Replacement	81.52	27125
Total Knee Replacement Revision	81.54 81.55 00.80–00.84	27445, 27446, 27447 27486, 27487
Transplants **Note:** Transplant facilities must be Medicare approved.)		
Bone Marrow Transplant		

Procedure	ICD-9-CM Code	CPT® Code
Autologous Allogenic	41.00, 41.01, 41.04, 41.07, 41.09 41.02, 41.03, 41.05, 41.06, 41.08	38241 38240, 38242
Heart Transplant	37.5, 37.51, 37.52, 37.53, 37.54	33945
Intestinal Transplant	46.97	44133, 44135, 44136, 44715, 44720,44721
Kidney Transplant	55.61 55.69	50323, 50325, 50327, 50328, 50329, 50360, 50365, 50380
Liver Transplant	50.59	47135, 47136, 47143, 47144, 47145, 47146, 47147
Note: Liver from live donor not a covered benefit		
Lung Transplant **Note:** Restricted to age 0 – 21	**33.50, 33.51**	**32850, 32851, 32852, 32853, 32854, 32855, 32856** **(*effective 7/1/08)***
Combined Heart-Lung Transplant	**33.6**	
Bariatric Surgery	44.31, 44.95	43644, 43645, 43845, 43846, 43847, 43848, 43770, 43771, 43772, 43773, 43774
Note: Procedure must be performed in a Medicare approved Bariatric Surgery Center (BSC) or Bariatric Surgery Center of Excellence (BSCE)		
Panniculectomy	86.83	15830, 15847, 15877
Alcohol and Drug Rehabilitation and Detoxification **Inpatient Only**		
Alcohol Rehabilitation	94.61	90899
Alcohol Detoxification	94.62	90899
Alcohol Rehabilitation and Detoxification	94.63	90899
Drug Rehabilitation	94.64	90899
Drug Detoxification	94.65	90899
Drug Rehabilitation and Detoxification	94.66	90899

Procedure	ICD-9-CM Code	CPT® Code
Combined Alcohol and Drug Rehabilitation	94.67	90899
Combined Alcohol and Drug Detoxification	94.68	90899
Combined Alcohol and Drug Rehabilitation and Detoxification	94.69	90899
Psychiatric Admissions- **Inpatient Only**	291.0 through 314.9 (Diagnosis Codes)	
Physical Rehabilitation - **Inpatient Only** Care involving use of rehabilitation procedures	V57.0 – V57.9 (Diagnosis Codes) This includes admission to all rehabilitation facilities, regardless of diagnosis.	
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Approved List of V-Codes That May Be Used for Principal Diagnoses

The V-Codes in the current ICD-9 CM book, Tabular List for V-Codes, listed as acceptable codes for use as a principal diagnosis will be used for pre-authorization and concurrent review purposes.

Only these V-Codes will be accepted by the Qualis Health nurse reviewers when performing pre-authorization or concurrent review for Idaho Medicaid clients.

3.3.3.7 Prior Authorization (PA)

Idaho Medicaid authorization is also required for the following inpatient procedures:

- Reconstructive surgery which is not on the QIO list.
- Plastic surgery which is not on the QIO list.
- Cosmetic surgery which is not on the QIO list.
- Elective surgery which is not on the QIO list.
- Administratively Necessary (AN) days.
- Excluded services found medically necessary in an early and periodic screening, diagnosis, and treatment (EPSDT) screen.

If a PA is required, the PA number must be included on the claim.

See *Section 2.3 Prior Authorization (PA)*, for more information on billing services that require PA.

Send or fax requests for PA and the required documentation to justify the medical necessity for these services to:

Division of Medicaid
Attn: Surgery Authorizations
PO Box 83720
Boise, ID 83720-0036
Fax (208) 332-7280

Healthy Connections participants require a referral from their PCP for all inpatient and outpatient hospital services in addition to a Medicaid or Qualis Health PA.

The following codes require a Medicaid PA. Physicians must request PA using the appropriate CPT® code:

Proc	Description
03.29	Other chordotomy.
03.93	Implantation or replacement of spinal neurostimulator lead(s).
11970	Replacement of tissue expander with permanent prosthesis
17106	Destruction of cutaneous vascular proliferative lesions, less than 10 sq cm.
17107	Destruction of cutaneous vascular proliferative lesions, 10.0 - 50.0 sq cm.
17108	Destruction of cutaneous vascular proliferative lesions, over 50.0 sq cm.
19316	Mastopexy.
19324	Mammoplasty, augmentation without prosthetic implant.
19325	Mammoplasty augmentation with prosthetic implant.
19328	Removal of intact mammary implant.
19330	Removal of mammary implant material.
19340	Immediate insertion of breast prosthesis.
19342	Delayed insertion of breast prosthesis.
19350	Reconstruction, nipple/areola.
19357	Breast reconstruct with tissue expander including subsequent expansion.
19361	Breast reconstruct with latissimus dorsi flap, with or without prosthetic implant.
19364	Breast reconstruction with free flap.
19366	Breast reconstruction with other technique.
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM).
19368	Breast reconstruction (TRAM), with microvascular anastomosis.
19369	Breast reconstruction.
19370	Open periprosthetic capsulotomy, breast.
19371	Periprosthetic capsulectomy, breast.
19380	Revision of reconstructed breast.
19499	Unlisted procedure, breast.
29999	Unlisted procedure, arthroscopy.
30462	Rhinoplasty; tip, septum, osteotomies.
36475	Endovenous ablation therapy of incompetent vein, extremity, radiofrequency.
36476	Endovenous ablation therapy of incompetent vein, second, and subsequent.
36478	Endovenous ablation therapy of incompetent vein, extremity, laser.
36479	Endovenous ablation therapy of incompetent vein, second, and subsequent.

Proc	Description
37700	Ligation and division of long saphenous vein.
37718	Ligation, division, and stripping, short saphenous vein.
37722	Ligation, division, and stripping, long (greater) saphenous veins.
37735	Ligation, division, and complete stripping of long or short saphenous veins, with excision of deep fascia
37760	Ligation of perforator veins, subfascial, radical, with or without skin graft, open.
37780	Ligation and division of short saphenous vein at saphenopopliteal junction.
37785	Ligation, division and/or excision of varicose vein cluster(s), one leg.
38.59	Leg varicose veins ligation and stripping.
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Revision or removal of gastric neurostimulator electrodes, antrum.
43659	Laparoscopy, unlisted stomach procedure.
43850	Revision of gastroduodenal anastomosis with reconstruction, without vagotomy.
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open.
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open.
48160	Pancreatectomy, total or subtotal, with autologous transplantation.
50.51	Auxiliary liver transplant, leaving patients own liver in situ.
52640	Transurethral resection of postoperative bladder neck contracture.
59866	Multifetal pregnancy reduction(s).
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to single electrode array.
63650	Percutaneous implantation of neurostimulator electrode array, epidural.
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural.
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct, or inductive coupling.
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver.
64553	Percutaneous implantation of neurostim. electrodes; cranial nerve
64555	Percutaneous implantation of neurostim. electrodes; peripheral nerve, excl sacral
64560	Percutaneous implantation of neurostim. electrodes; autonomic nerve
64561	Percutaneous implantation of neurostim, electrodes; sacral nerve, transforaminal
64565	Percutaneous implantation of neurostimulator electrodes; neuromuscular
64573	Incision for implant of neuro electrodes, cranial nerve.
64575	Incision for implant of neurostim. electrodes, peripheral nerve, excludes sacral nerve
64577	Incision for implant of neuro electrodes, autonomic nerve.
64580	Incision for implant of neurostim.electrodes,

Proc	Description
64581	Incision for implant of neurostim. Electrodes, sacral nerve, transforaminal placement
64585	Revision or removal of peripheral neurostim. electrodes
64590	Insertion or replacement of peripheral gastric neurostimulator pulse generator or receiver, direct or inductive coupling.
64595	Revision or removal of peripheral or gastric neurostim. pulse generator or receiver
64999	Unlisted procedure, nervous system.
69714	Implantation, osseointegrated implant, temporal bone.
69715	Implantation, osseointegrated implant, temporal bone, with mastoidectomy.
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone.
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with mastoidectomy.
69930	Cochlear device implant, with or without mastoidectomy.
85.53	Unilateral breast implant.
85.54	Bilateral breast implant.
85.70	Total reconstruction of breast, not otherwise specified.
85.71	Latissimus dorsi myocutaneous flap
85.72	Transverse rectus abdominis mycutaneous (TRAM) flap, pedicled
85.73	Transverse rectus abdominis mycutaneous (TRAM) flap, free
85.74	Deep inferior epigastric artery perforator (DIEP) flap, free
85.75	Superficial inferior epigastric artery (SIEA) flap, free
85.76	Gluteal artery perforator (GAP) flap, free
85.79	Other total reconstruction of breast
85.83	Breast full-thick graft.
85.84	Breast pedicle graft.
85.85	Breast muscle flap graft.
85.87	Nipple repair nec.
85.93	Breast implant revision.
85.94	Breast implant removal.
85.95	Insert breast tissue expander.
85.96	Remove breast tissue expander.
85.99	Breast operation nec.
86.94	Insertion or replacement of single array neurostimulator pulse generator.
86.95	Insertion or replacement of dual array neurostimulator pulse generator.
86.96	Insertion or replacement of other neurostimulator pulse generator.
86.97	Insertion or replacement, single array n.s. pulse generator, rechargeable.

Proc	Description
86.98	Insertion or replacement, dual array n.s. pulse generator, rechargeable.
87903	Phenotype analysis by DNA/RNA, HIV 1, 1 - 10 drugs tested.
87904	Phenotype analysis by DNA/RNA, HIV 1, each additional 1 - 5 drugs.
97799	Unlisted physical medicine/rehabilitation service or procedure.
99.99	Other miscellaneous procedures, other.

3.4 Consultations

3.4.1 Overview

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and management of a specific problem is requested by another physician or other appropriate practitioner of the healing arts. A physician consultant may initiate diagnostic and therapeutic services.

The request for a consultation from the attending physician or other appropriate practitioner and the need for the consultation must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting physician or other appropriate source.

If a consultant subsequently assumes responsibility for management of a portion or all of the participant's condition(s), the consultation codes should not be used. In the hospital setting, the physician receiving the participant for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established participant code should be used.

3.5 Emergency Department/Critical Care Services

3.5.1 Overview

An emergency department is defined as organized hospital-based facilities for the provision of unscheduled temporary services to participants who come in for immediate medical attention. The facility must be available 24 hours a day.

Idaho Medicaid pays hospitals for six emergency department visits per participant, in any calendar year.

Use codes **99281** - **99285** to report evaluation and management services provided in the emergency department. No distinction is made between new and established participants in the emergency department.

3.5.2 Critical Care Services

Critical care includes the care of critically ill participants in a variety of medical emergencies that requires the constant attention of the physician. Critical care is usually, but not always, given in a critical care area, such as the Coronary Care Unit, Intensive Care Unit, Respiratory Care Unit, or the emergency care facility.

The following services are included in the global reporting and billing of critical care when performed during the critical period by the physician providing critical care:

- Interpretation of cardiac output measurements.
- Interpretation of chest x-rays.
- Pulse oximetry.
- Blood gases, and information data stored in computers (*e.g.*, electrocardiogram (ECG), blood pressure, hematologic data).
- Gastric intubation.
- Temporary transcutaneous pacing.
- Ventilator management.
- Vascular access procedures.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill participant.

Use code **99291** for critical care, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injuries or comatose participant, requiring the prolonged presence of the physician.

This code is used to report the first 30 - 74 minutes of critical care on a given day. **99291** is only billed as one unit. It should be used only once per day even if the time spent by the physician is not continuous on that day. **99291** is paid to a physician once per day.

Use code **99292** to bill each additional 30 minutes of critical care. This code is used to report each additional 30 minutes beyond the first 74 minutes. Bill code **99292** in 30 minute units.

3.5.3 Other Procedures

Other procedures that are not directly connected to critical care management (the suturing of laceration, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap, etc.) are not included in the critical care and should be reported separately.

3.5.4 Prolonged Services

Use codes **99354** - **99357** when a physician provides prolonged service involving direct (face-to-face) participant contact that is beyond the usual service in an inpatient or outpatient setting.

Use code **99354** or **99356** to report the first hour of prolonged service on a given date, depending on the place of service. Prolonged service lasting less than 30 minutes on a given date is not separately reported, because the work involved is included in the evaluation and management codes.

Use code **99355** or **99357** to report each additional 30 minutes beyond the first hour, depending on the place of service. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

3.6 Laboratory Coverage

3.6.1 Physician Office Laboratories

Physician office or group practice office laboratories must hold a current Clinical Laboratory Improvement Amendments (CLIA) certificate on file with EDS before Medicaid will reimburse for testing performed in the laboratory. Payments will be denied to any laboratory submitting claims for services not covered by their CLIA certificate. Claims for services rendered outside the effective dates of their CLIA certificate will be denied.

Physicians can bill for clinical diagnostic laboratory services they personally performed or supervised.

Physician performed or personally supervised diagnostic laboratory tests are reimbursed at the rate established by Medicaid.

Physician owned laboratories cannot bill for tests sent to independent laboratories or pathology laboratories.

An office visit cannot be billed when a participant comes in for a blood draw by a lab technician and does not see the doctor. The lab technician's cost is included in the lab procedure payment.

3.6.2 Independent Laboratories

Independent laboratories are not affiliated with a specific physician's office and have a separate provider number. They are able to do testing for multiple groups of physicians. Independent laboratories must bill Idaho Medicaid directly for the services they render.

3.6.3 Laboratory Procedures

Only the following CPT lab codes can be broken out into a professional and technical component:

88104 - **88125**

88160 - **88162**

88172 - **88173**

88182

88300 - **88319**

88323

88331 - **88334**

88342 - **88368**

88385 - **88386**

In place of service **21** (Inpatient), **22** (Outpatient), and **23** (Emergency) the procedure codes should be billed with a **26** modifier, unless there is a procedure code that says, *Supervision and Interpretation Only*. The hospital will bill for the technical component on its UB-04 claim form.

If a pathologist has their own office and equipment, they may bill and be paid for the complete test including those that cannot be broken out into the professional and technical components.

3.6.4 Diagnostic Codes

A valid diagnosis code must always be indicated on the claim form. If the laboratory provider is unable to obtain the correct diagnosis, use diagnostic code **V72.6** as the primary diagnosis.

3.6.5 Venipuncture

Use procedure code **36415** for routine venipuncture and collection of specimens.

3.6.6 Presumptive Eligibility (PE)/Pregnant Women (PW) Services

Services rendered to pregnant women who qualify for Medicaid under the PE or PW Program must have a pregnancy diagnosis or documentation to substantiate how the service was pregnancy related. Services for pregnant women under the age of 21 who are on Medicaid's PE or PW Program do not have Preventive Medicine or early and periodic screening, diagnosis, and treatment (EPSDT) service benefits.

When in question, a provider can request a signed Medical Necessity form (pregnancy related) from the referring physician and attach the form to their claim. This form is available in the *Idaho Provider Handbook, Appendix D; Forms* at: **http://www.healthandwelfare.idaho.gov/site/3438/default.aspx**

See *Section 1.3 Participant Eligibility,* for more information on PE, PW, and Medical Necessity forms (pregnancy related).

3.6.7 Special Services

Handling and conveyance of specimens for transfer from the participant to a place other than a physician's office/place of service **12** (Residence) or **32** (Nursing Home) to a laboratory is covered by Medicaid when billed with procedure code **99001**.

3.6.8 Blood Lead Screening for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Federal mandate requires that a screening for lead poisoning be a required component of an EPSDT screen. Current Centers for Medicare and Medicaid Services (CMS) policy requires a screening blood lead test for all Medicaid eligible children at 12 and 24 months of age. In addition, children over the age of 24 month, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test.

3.6.9 Modifiers

When a repeat procedure is ordered on the same day for the same participant, report with modifier **91**. Idaho Medicaid will pay the lab directly and does not accept modifier **90**.

3.7 Ophthalmology Policy

3.7.1 Overview

Medicaid covers one complete visual examination annually (every 365 days) to determine the need for eyeglasses to correct a refractive error without prior authorization. General policy, covered services, limitations, and exclusions can be found in Section 3 Vision Services, at the link listed below.

http://www.healthandwelfare.idaho.gov/site/3438/default.aspx

Note: Evaluation and management procedures are paid only for an eye injury or disease. Medicaid requires the appropriate eye exam procedure code to be billed for all other eye exams.

If the participant requests; it is required that a copy of the prescription be provided to the participant.

Order all vision supplies (frames, lenses, contact lenses) from Idaho Medicaid's vision products contractor, who will bill Medicaid for the supplies. Products obtained through any other lab can not be reimbursed. The optical provider bills Medicaid for the examination, a fitting or dispensing fee, and repairs.

To see the complete catalog of frames and to place on-line orders, go to Barnett and Ramel Optical on the Web at: **http://broptical.com**.

Submit eyeglass orders to the following address:

Barnett and Ramel Optical (B&R Optical)
7154 N. 16th Street
Omaha, NE 68112
Fax: (800) 545-2693

3.8 Psychiatric Service Limits

3.8.1 Overview

Medicaid covers preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided by a psychiatrist in an inpatient or outpatient setting. A psychiatrist billing for these services will use their own physician provider number, rather than the provider number from a Mental Health Clinic in which they may also be a participant.

Refer to the *Current Procedural Terminology® (CPT) Manual* for procedure codes to bill psychotherapy services.

3.8.2 Outpatient Psychiatric Care

The benefit for Idaho Medicaid participants is limited to 12 hours of psychiatric evaluations in a calendar year (January to December) from all professionals. Psychotherapy services provided in either group or individual sessions are limited to 45 hours of treatment per calendar year, from all professionals.

3.8.3 Telemedicine

Limited mental health services may be provided via telemedicine technology if the telecommunications permit real-time communication between the physician and the participant. Details of requirements are described in Information Release MA04-37, available online at: **http://www.healthandwelfare.idaho.gov/DesktopModules/ArticlesSortable/ArticlesSrtView.aspx?tabID=0&ItemID=1356&mid=10309**.

Telemedicine Services (May only be performed by a physician)		
Pharmacological Management	**90862** **GT** Modifier Required	Including prescription, use and review of medication with no more than minimal medical psychotherapy.
Psychotherapy	**90805** **GT** Modifier Required	20 - 30 minute session with medical evaluation and management services.
Psychiatric Diagnostic Interview, Exam	**90801** **GT** Modifier Required	Psychiatric diagnostic interview examination. 1 Unit = 15 minutes
Telehealth Originating Site Transmission	**Q3014**	1 Unit + 1 Originating Site Transmission
Telehealth Distant Site Transmission	**T1014**	1 Unit + 1 Distant Site Transmission

3.8.4 Inpatient Psychiatric Care

There are no limitations to inpatient psychiatric care when the participant is hospitalized in a general acute care hospital (all acute hospital stays beyond three days do require a Quality Improvement Organization (QIO) authorization). See *Sections 3.3 Medical/Surgical Review,* for more on QIO.

For more information on mental health services see, *Section 3 Clinic Guidelines.*

The Department of Health and Welfare (DHW) will pay for prior authorized medically necessary inpatient psychiatric hospital services in a free-standing psychiatric hospital, (an institution for mental disease) for participants under the age of 21 who have a DSM IV diagnosis with substantial impairment in mood, perception, or behavior.

Admissions to freestanding psychiatric hospitals not contracted with DHW are not covered by Medicaid. OBRA ‘90 provides for psychiatric care for Medicaid coverage of hospital admissions with drug and

alcohol related primary diagnoses. All admissions require a QIO authorization, which includes review for less restrictive services by the Regional Mental Health Authority (RMHA).

Refer to the *Qualis Health Provider Manual, Section X* for details. The *Idaho Medicaid Provider Manual* may be found on online at: **http://www.qualishealth.org/cm/idaho-medicaid/manual.cfm,** or call Qualis Health at: **(800) 783-9207 (toll free)**

Note: Medicaid Basic Plan participants are limited to ten days of inpatient mental health services per year.

3.9 Obstetric (OB) Care

3.9.1 Overview

Medicaid covers total obstetrical care, including:

- Antepartum care.
- Delivery.
- Postpartum care.

Obstetric (OB) care must be billed as a global charge unless the attending physician (or another physician working in the same practice) did not render all components of the care. Antepartum care may be billed separately from the delivery and postpartum care only when the services were rendered by different group or billing physicians.

High risk pregnancy case management services are now available to support providers in caring for Idaho Medicaid participants. Pregnant women who are at risk for premature labor or congenital issues of the fetus may be referred to a Qualis Health Case Manager, who will telephonically assist with the coordination of in-home and community support services. To make a referral:

- Contact Qualis Health at: **(800) 783-9207** and request, Case Management Services.
- A nurse case manager will send a packet of information to the participant with information about the voluntary, no-cost service.
- If the participant wishes to participate, she will return the signed form to Qualis Health.

3.9.2 Total Obstetric (OB) Care

Total OB care includes cesarean section or vaginal delivery, with or without episiotomy, with or without forceps, or breech delivery.

Charges for total OB care must be billed after the delivery. The initial office examination for diagnosis of a pregnancy may be billed separate from the total OB charges if that is the provider's standard practice for all OB participants. If the participant is new to the office, a new participant office visit code should be used. The initial examination must be identified as such and billed with the appropriate Evaluation and Management (E/M) CPT code.

Prenatal diagnostic laboratory charges, such as a complete urinalysis, should be billed as separate charges using appropriate CPT codes. If an outside laboratory, not the clinic, did services, the lab must bill Medicaid directly.

Resuscitation of the newborn infant is covered separately if billed under the child's name and Medicaid identification (MID) number.

3.9.2.1 Place-of-Service (POS) Code

The POS code for total OB care is normally **21** (Inpatient), and must be in field **24B** on the CMS-1500 claim form, or in the appropriate field of the electronic claim.

3.9.3 Antepartum Care

Antepartum care includes the following usual prenatal services:

- Recording weight, blood pressure, fetal heart tones.
- Routine dipstick urinalyses.
- Maternity counseling.

3.9.3.1 Billing for Incomplete Antepartum Care

If the physician sees the participant for part of the prenatal care but does not deliver, submit charges only for the services rendered.

When billing for the initial physical examination and the second or third follow up visit, use the appropriate E/M CPT code.

Any laboratory services not previously submitted can be billed using the appropriate CPT code. Do not bill for lab charges sent to an outside laboratory. Bill only for the services rendered.

When billing for four to six prenatal visits, use CPT code **59425** with the total charge for all visits on one line. Do not split-out each visit. Enter the first date of service in the, From Date field on the CMS-1500 claim form and the last date of service in the, To Date field. Note the date for each visit that falls between the, From Date of service and the, To Date of service in field **19** on the CMS-1500 claim form or the comment field of the electronic claim. These services would need to be split out to different claims when the participant is not on the Healthy Connections (HC) Program the entire time.

When billing for seven or more prenatal visits with or without an initial visit, use CPT code **59426** with the total charge and the description, *Antepartum Care Only*, on one line with one charge. The From Date of service should be the date of first prenatal visit and the, To Date of service should be the date of the last prenatal visit. Note the date for each visit that falls between the, From Date of service and the, To Date of service in field **19** on the CMS-1500 claim form or the comment field of the electronic claim form. These services would need to be split out to different claims when the participant is not on the HC Program the entire time.

3.9.4 Postpartum Care

Postpartum care includes hospital and office visits in the 45 days following vaginal or cesarean section delivery. Postpartum care also includes contraceptive counseling.

3.9.5 Billing for Twin Deliveries

Delivery of first baby should be billed with the appropriate CPT code, 1 unit, and only the charges for the first delivery. Delivery of the second baby should be billed with a delivery code (**59409**, **59514**, **59612**, or **59620**), modifier **51**, one unit, and only the charges for the second delivery. All antepartum or postpartum care should be included in the delivery code for the first baby.

3.9.6 Presumptive Eligibility (PE)/Pregnant Women (PW) Services

The PE and the PW Programs are outlined in *Section 1.4.3 Presumptive Eligibility (PE) and 1.4.4 Pregnant Women (PW)*. Please refer to, *Excluded Services,* under these sections for more information.

3.9.6.1 Billing Presumptive Eligibility (PE) Determinations

To bill for the completion of a PE determination, follow these procedures:

- Participant and provider complete program questions and determine if participant is eligible for the PE Program. Provider sends the application for services to the participant's regional field office.
- Participant's local field office processes the application for services and issues a Medicaid number for the participant's PE period.
- Participant's PE period ends after a maximum coverage period of 45 days or sooner if the candidate is eligible for PW or another Medicaid program.
- Participant's eligibility must be verified by the provider using Medicaid Automated Voice Information Service (MAVIS) or electronic software. See *Section 1 General Provider and Participant Information*, for instructions on verifying eligibility.
- Use HCPCS code **T1023** to bill for PE determination.
- Include the participant's full name, MID number, and date of birth.

The PE Program covers only outpatient ambulatory pregnancy related services. A delivery cannot be billed under the PE Program regardless of the setting.

3.9.6.2 Billing for Presumptive Eligibility (PE) or Pregnant Women (PW) Services

Claims submission for PE or PW participants should follow the same billing practices as those for any pregnant Medicaid participant. Services rendered must be a direct result of or directly affect the pregnancy.

Prenatal clinics can bill only the special services procedure codes and laboratory services under the prenatal clinic provider number.

3.9.6.3 Medical Necessity Form

The PE and PW Programs are for pregnancy related services only. All services that are not clearly pregnancy related must have supporting documentation to justify the service. Providers may use a Medical Necessity form and attach the form to their claim. This form is available in the *Idaho Provider Handbook, Appendix D; Forms* at: **http://www.healthandwelfare.idaho.gov/site/3438/default.aspx**.

Each claim is reviewed on a case by case basis by the EDS medical consultant. If a claim is denied with an Explanation of Benefits (EOB) code that states, *This PW Participant's Charge has been Reviewed by the EDS Medical Consultant and Denied*, the provider may request further review from Medicaid. Send appeals to:

Idaho Medicaid
MAS – Appeals
PO Box 83720
Boise, ID 83720-0036

3.10 Abortions

3.10.1 Overview

Medicaid will cover a legal therapeutic abortion in order to save the life of the mother or in cases involving rape or incest.

Medicaid will pay in cases of rape or incest, as determined by a court or reported to a law enforcement agency. A copy of the court determination or documentation of the report to law enforcement may be attached to the claim to expedite payment. If the rape or incest was not reported to law enforcement, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health. The certification must contain the name and address of the woman. When determination of the rape is based on age, the certification must show that the woman was under the age of 18 at the time of the sexual intercourse.

When a pregnancy is life threatening, Medicaid will cover an abortion to save the life of the woman. One licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. See *Section 3.10.4 Sample Certification of Necessity for Abortions*, for a sample of the certification that the physician must complete.

3.10.2 Hospitalization

Hospital charges for a therapeutic abortion are subject to the same restrictions as the physician's charges. The physician should send a copy of the properly completed Certification of Necessity form to the hospital for the participant. The hospital is required to attach a copy of the Certification of Necessity form to its claim.

3.10.3 Exception

Medicaid does not pay for any type of abortion for participants on the Presumptive Eligibility (PE) Program. Also, PE participants are not covered for any delivery services.

3.10.4 Sample Certification of Necessity for Abortions

I, _____ (Name of physician),

attending physician to _____ (Name of participant),

certify that in my professional judgment, allowing this participant's present pregnancy to be carried to term will endanger her life.

Date: _____

Signature of physician: _____

Name of participant: _____

Address of participant: _____

_____

_____

_____

3.11 Hysterectomies

3.11.1 Overview

Medicaid only pays for hysterectomies if the following criteria are met:

- Substantiating documentation of medical necessity must be attached to the claim form.
- Rendering the participant permanently incapable of reproducing was not the sole purpose of the surgery.
- Participant was advised both verbally and in writing that the hysterectomy would result in permanent sterility and that she will no longer be able to bear children.
- The Authorization for Hysterectomy form, or an equivalent authorizing form, must be signed by the participant, regardless of the participant's age or reproductive capabilities.
- Prior authorization (PA) is on file at EDS.

The Authorization for Hysterectomy form may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the participant must sign a statement clearly stating that she was informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render her sterile. See *Section 3.11.2 Sample Authorization for Hysterectomy Form,* for an example.

The Authorization for Hysterectomy form must be on file at EDS before any claims can be paid.

Approval from the Quality Improvement Organization (QIO), Qualis Health, must be obtained and the PA number entered on the claim form in field **23** of the CMS-1500 claim form, or field **63** of the UB-04 claim form.

3.11.2 Sample Authorization for Hysterectomy Form

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Signature: _____

Date: _____

3.12 Family Planning Services

3.12.1 Overview

Family planning includes counseling and medical services prescribed or performed by an independent licensed physician. Specific items covered are services for diagnosis, treatment, related counseling, and restricted sterilization.

Note: Family planning services do not require a Healthy Connections (HC) referral.

3.12.2 Contraceptive Supplies

Medicaid will pay for contraceptive supplies including prescription diaphragms, intrauterine devices (IUDs), implants, injections, contraceptive patches, and oral contraceptives.

Note: The Morning-after Pill, Plan B, is not covered.

3.12.3 Limitations

Payment for oral contraceptives is limited to the purchase of a three month supply when purchased through a pharmacy.

Payment to providers of family planning services is limited to Department of Health and Welfare (DHW) fee schedule.

Medicaid does not pay a physician's office for take-home contraceptives, except those inserted or fitted by the provider, such as an IUD, Norplant, or diaphragm.

3.12.4 Billing Information

All claims for services or supplies that are provided as part of a family planning visit must include the **FP** (Family Planning) modifier with the CPT or HCPCS.

Additionally, claims for family planning services and supplies should include one of the diagnoses listed in the table below as the primary diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive.
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents).
V25.09	Family planning advice (other).
V25.1	Insertion of IUD.
V25.2	Sterilization (admission).
V25.40	Contraceptive surveillance, unspecified.
V25.41	Contraceptive pill surveillance.
V25.42	IUD (checking, reinsertion, or removal of device) surveillance.
V25.43	Implantable subdermal contraceptive surveillance.
V25.49	Surveillance of other contraceptive method.
V25.5	Insertion of implantable subdermal contraceptive.
V25.8	Other specified contraceptive management (post-vasectomy sperm count).
V25.9	Unspecified contraceptive management.

See *Section 3.12.4.5 Family Planning Diagnoses/Modifier,* for more information.

Supplies billed with **J3490** (Unclassified Drug*)* require the NDC (National Drug Code), quantity dispensed, and basis of measure to be reported on the claim form. See *Section 3.18.6.3 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes,* for more information.

3.12.4.1 Intrauterine Device (IUD)

When billing for IUDs, use the following procedure codes (with modifier **FP**):

J7300 Intrauterine copper contraceptive.

J7302 Mirena IUD.

58300 Insertion of IUD.

58301 Removal of IUD.

When billing **J** codes, the appropriate NDC must be billed with the procedure code. Medicaid pays for the IUD insertion, but does not cover any separate fees for the office exam. However, an office exam may be billed at the time of insertion, if the participant was treated for an unrelated diagnosis. Attach modifier **25** to the evaluation and management (E/M) CPT code.

3.12.4.2 Norplant

Norplant contraceptive services must be billed using the following procedure codes (with modifier **FP**):

11975 Insertion, implantable contraceptive capsules.

11976 Removal, implantable contraceptive capsules.

11977 Removal with reinsertion, implantable contraceptive capsules.

J7306 Levonorgestrel (contraceptive) implants system, including implants and supplies (Norplant kit). NDC required.

3.12.4.3 Depo-Provera and Lunelle Injectables

Depo-Provera and Lunelle injectables must be billed using the following procedure codes (with modifier **FP**):

J1055 Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Depo-Provera).

J1056 Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Lunelle).

When billing **J** codes, the appropriate NDC must be billed with the procedure codes. When Depo-Provera is used for any purpose other than contraception or for dosages up to 100 mg, use **J3490** (Unclassified Drug) and indicate the NDC, quantity dispensed, and units of measure. See Medicaid Information Release MA03-69 online at:
http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3430/DesktopDefault.aspx

3.12.4.4 Diaphragm

When billing for a diaphragm, use the following codes (with modifier **FP**):

A4266 Diaphragm for contraceptive use.

57170 Diaphragm or cervical cap fitting with instructions.

3.12.4.5 Family Planning Diagnoses/Modifier

Any services provided as part of a family planning visit should include one of the diagnoses listed in the table below as the primary diagnosis. Attach modifier **FP** (Family Planning) to the E/M CPT code. Failure to report a family planning diagnosis and the CPT with the **FP** modifier, increases the direct cost of services to the Idaho Medicaid Program, and will cause claims to deny if they do not include a HC referral.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive.

Diagnosis Code	Description
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents).
V25.09	Family planning advice (other).
V25.1	Insertion of IUD.
V25.2	Sterilization (admission).
V25.40	Contraceptive surveillance, unspecified.
V25.41	Contraceptive pill surveillance.
V25.42	IUD (checking, insertions, or removal of device) surveillance.
V25.43	Implantable subdermal contraceptive surveillance.
V25.49	Surveillance of other contraceptive method.
V25.5	Insertion of implantable subdermal contraceptive.
V25.8	Other unspecified contraceptive management (post-vasectomy sperm count).
V25.9	Unspecified contraceptive management.

3.13 Sterilization Procedures

3.13.1 Overview

Sterilizations (tubal ligations/vasectomies) do not require QIO approval; however, regulations concerning participant information and consent require strict adherence.

3.13.2 Participant Consent

The participant must be at least 21 years of age at the time the consent form is signed and prior to performing the procedure.

The participant must be mentally competent in order to give consent.

There must be a lapse of 30 days between the time the participant signs the consent form and the time the sterilization is performed. However, not more than 180 days can lapse after the participant signs the consent and the procedure is performed. In other words, the time span looks like this:

Day 1 Participant signs form. This does not count as the first day.

Day 2 Count begins and 30 days must lapse. This counts as the first day.

Day 32 First day surgery can be performed.

Day 181 Last day surgery can be performed.

The intent of the rules and the federal requirements that 30 days must lapse are to allow the participant time to think about the decision to be sterilized. The physician who does the surgery need not be the physician who obtains the consent from the participant. However, the physician who performs the surgery must also sign the consent form, but the 30 day lapse need not be met again, as long as the participant signed a consent form at least 30 days prior to surgery.

Note: A valid consent form must be on file before payments can be made.

3.13.3 Waiting Time Exceptions

If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than 30 days, but no less than 72 hours after the date of the participant's signature on the consent form. The surgeon must certify the following information in paragraph 2 of the physician's statement of the consent form:

- The expected delivery date and provide written details of the premature delivery.
- The emergency nature of the abdominal surgery in writing.

Under no circumstance can the period between consent and sterilization exceed 180 days.

Failure to properly complete the physician's statement of the consent form will result in claim denial.

The only consent form for sterilizations that is authorized and accepted by Idaho Medicaid may be obtained by contacting EDS.

3.13.4 Interpreter Services Concerning Sterilizations

Suitable arrangements must be made to ensure that information is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped.

An interpreter must be provided if the participant does not understand either the language used on the consent form or spoken by the person obtaining the consent. Providers may bill Medicaid for reimbursement for oral or sign language interpreter services that they provide for participants. Interpreters may not bill Medicaid directly for their services.

Oral Interpretive Services:

Providers may bill Medicaid for reimbursement of oral interpreter services. Report procedure code **8296A** (Interpretive Services), which encompasses oral interpretive services regardless if the interpreter is certified, partially certified, non-certified, or is providing language services.

Sign Language Interpretive Services:

Providers may bill Medicaid for reimbursement of sign language interpreter services. Report procedure code **T1013** (Sign Language Interpretive services). Bill 1 Unit per 15 minutes.

The interpreter must sign and date the consent form the same day the participant's signature and date is obtained.

The interpreter certifies:

- The information and advice was accurately translated and verbally presented to the participant.
- The consent form was read and accurately explained to the participant.
- To the best of their knowledge and belief, the participant understood the interpreter.

If the interpreter fails to complete the statement correctly, all claims regarding the sterilization, including physician, hospital, and anesthesiologist charges, will be denied. Medicaid will not accept corrected or altered consent form

3.13.5 When Not to Obtain Consent

Informed consent must not be obtained while the participant is in any of the following conditions:

- In labor or childbirth.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or other mind altering substances.

3.13.6 Signature Requirements

The participant must voluntarily sign and date the consent form in the presence of the person obtaining the consent.

3.13.6.1 The Witness Certifies

Before the participant signs and dates the consent form, they are advised federal benefits would not be withheld regardless of their decision to be sterilized or not to be sterilized.

- The requirements on the consent form were verbally explained to the participant.
- To the best of the witness' knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization.

The person obtaining consent may sign the form anytime on or after the date the person giving consent signed the form. If the physician obtains the participant's signature, then the physician must sign both statements on the form, once as the person obtaining the consent and again as the physician performing the surgery.

If the person obtaining consent fails to complete the statement correctly, all claims regarding the sterilization, including physician, hospital, and anesthesiologist charges, will be denied. Medicaid will not accept corrected or altered consent forms. Corrections to the participant signature and signature date are not allowed. The providers of service may not bill the participant if this error is made.

3.13.7 Physician's Certification

The physician must sign the consent form certifying that the requirements per the *IDAPA 16.03.09.681 Medicaid Basic Plan Benefits* have been fulfilled. These rules are available online at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf**

The signature of the physician performing the sterilization must be obtained not more than three days prior to surgery or any time after the surgery. A copy of the completed consent form must be submitted with the claim form.

3.14 Anesthesia Services

3.14.1 Overview

Medicaid accepts anesthesia codes from the anesthesia section of the *Current Procedural Terminology (CPT) Manual*. Anesthesia claims must use the CPT anesthesia code that relates to the surgical procedure performed on the participant.

Anesthesia time begins when the anesthesiologist physically starts to prepare the participant for the induction of anesthesia in the operating room and ends when the anesthesiologist is no longer in constant attendance.

Medicaid does not pay for supervision of anesthesia services. The provider who administers the anesthesia, either a physician or Certified Registered Nurse Anesthetist (CRNA) is paid 100 percent of the allowed amount for the procedure.

3.14.1.1 Billing Instructions

Enter the CPT anesthesia code for the surgical procedure that was performed on the participant, total amount of time in minute increments, and any necessary modifiers from, *Section 3.14.3 Modifiers*.

Idaho Medicaid limits reimbursement for anesthesia procedures to once per day. A repeat anesthesia procedure on the same day which is billed with the CPT modifier **76** or **77** will be paid at $0.00. Medicaid considers that a second separate session of anesthesia has occurred when a patient is returned to surgery after spending time in another unit of the hospital. In these cases, Medicaid will reimburse both CPT anesthesia codes plus the total time for both sessions, with adequate documentation.

3.14.2 Modifiers

Up to four modifiers may be used. Only use the modifiers in the table.

Modifier	Description
AA	Anesthesia services personally performed by an anesthesiologist. The **AA** modifier is used for all basic procedures.
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures.
P1	Normal healthy patient.
P2	Patient with mild systemic disease.
P3	Patient with severe systemic disease.
P4	Patient with severe systemic disease that is a constant threat to life.
P5	Moribund patient who is not expected to survive without the operation.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
QS	Monitored anesthesia care service (can be billed by CRNA or a physician). Modifier **QS** (Monitored Anesthesia Care) is for informational purposes. Please report actual monitoring time on the claim form. This modifier must be billed with another modifier to show that the service was personally performed or medically directed.
QX	CRNA service, with medical direction by a physician.
QY	Medical direction of one 1 CRNA by an anesthesiologist.
QZ	CRNA service, without medical direction by a physician.

Modifier **22** should not be used with, or in place of, the appropriate modifier(s) when billing unless the services would require the use of more than three of the modifiers listed above. Use the CPT anesthesia code that most accurately describes the procedure performed. The use of modifier **22** overrides any other modifier indicated.

3.14.3 Epidural Billing

To bill for the epidural injections use the appropriate CPT procedure codes.

3.14.3.1 Units

Enter total units (minutes) for time only in field **24G** of the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.14.3.2 Diagnosis Code

Use code **999.9** if the procedure is due to an injury and **799.9** if not. The appropriate code must be used for abortions and dilation and curettage (D & C) procedures. Diagnosis code **V25.2** must be used for sterilizations. Enter the diagnosis code in field **21** of the CMS-1500 claim form or in the appropriate field of the electronic claim.

3.15 Surgery Guidelines

3.15.1 Global Fee Concept

Medicaid pays all surgical fees based on the global fee concept. Global service includes:

- Examination of the participant immediately before the surgery or upon admission to the hospital.
- Performance of the surgical procedure and in-hospital follow-up care.
- Follow-up visits in the office.

3.15.2 Complications

Complications are not considered part of a normal procedure and additional services for the treatment of complications should be billed accordingly.

Use appropriate CPT codes and modifiers for the billing of complications.

3.15.3 Modifiers

Modifiers are mandatory in certain circumstances. Refer to the *Current Procedural Terminology (CPT) Manual* for specific guidance using modifiers.

In order to recognize assistant-at-surgery services provided by a physician assistant or nurse practitioner (mid-level practitioners), surgical codes should be billed under the mid-level practitioner number with an **AS** modifier.

AS Physician Assistant or Nurse Practitioner services for assistant-at-surgery (Medicare Part B bulletin GR00-3).

The surgical modifiers listed below pay a percentage of the Idaho Medicaid fee schedule.

Modifier	Percentage Of Fee Schedule	Modifier Description
54	80%	Surgical care only
55	20%	Post-op management only
58	80%	Staged or related procedure or service by same physician during post-op period
62	62.5% each	Two surgeons
78	80%	Unplanned return to operating room for a related procedure following initial procedure for related procedure during post-op period
80	20%	Assistant surgeon
81	20%	Minimum assistant surgeon
82	10%	Assistant surgeon

Note: Correct modifier use is required and is an important part of avoiding fraud and abuse or noncompliance issues.

When billing an E/M code on the same day that a surgical code or another E/M code has been or will be billed, then append modifier **25** or **57** to the E/M code. This is regardless of whether both services were provided by the same or different providers.

3.15.4 Hospital Admissions

If the surgery is elective or non-trauma, the hospital admission is included in the fee for surgery. If the surgery is the result of an emergency or trauma situation, the hospital admission can be paid in addition to the surgery. Indicate in field **24C** of the CMS-1500 claim form or in the electronic claim form emergency indicator when the admission is trauma or emergency related.

3.16 Radiology Procedures

3.16.1 Overview

Radiology procedures are for those radiological services performed by or under the supervision of a physician. Payment includes the professional component plus the technical component of the procedure. Services included are:

- Performance or supervision of the procedure.
- Interpretation and writing of an examination report.
- Consultation with referring physician.

3.16.2 Professional Component

The professional component represents services of the physician (radiologist) to interpret and report on the procedure. To identify a charge for the professional component, use the appropriate 5-digit CPT procedure code followed by modifier **26**. This component is applicable in any situation in which the physician does not provide the technical component as described below.

The professional component does not include the cost of personnel, material, space, equipment, or other facilities.

3.16.3 Technical Component

The technical component includes charges for the following:

- Personnel.
- Material, including usual contrast media and drugs.
- Film or xerograph.
- Space, equipment, and other facility charges.

To identify a charge for the technical component, use the appropriate 5-digit CPT code followed by modifier **TC**.

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. To be assured of adequate reimbursement, attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs to providers and the radioisotopes billed, this information is necessary to adequately price each claim.

3.16.4 Place-of-Service (POS) Codes

X-ray procedure codes billed in POS **21** (Inpatient), **22** (Outpatient), or **23** (Emergency) should be billed with a **26** modifier unless there is a procedure code with a description that says, *Supervision and Interpretation Only*. If the procedure code description says, *Supervision and Interpretation Only*, use this code without the **26** modifier since it is stating this is the professional component. The **TC** (Technical Component) is billed by the facility that owns the equipment and must be included on the claim.

3.16.5 Place-of-Service (POS) (Office)

In POS **11** (Office), if the physician owns the x-ray equipment, and also supervises and interprets the x-ray, the physician may bill for the complete procedure using no modifier. If the physician uses their equipment but sends the x-ray to a radiologist for interpretation, they must use the **TC** modifier.

3.16.6 Diagnosis Codes

When billing for either the professional or technical component, the correct diagnosis code should be used. If the provider is unable to obtain the diagnosis from the primary physician, it is acceptable to use **V72.5**, except for sterilizations or abortions.

3.17 Child Wellness Exams

Complete information regarding child wellness exams is located in *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT),* in the *General Provider and Participant Information Guidelines*. Sometimes child wellness exams are referred to as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens.

3.18 Other Billing Procedures

3.18.1 Foster Care

Program enrollment physicals for foster children are eligible for payment by Medicaid as a child wellness exam. See *Section 1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) in the General Provider and Participant Information Guidelines.*

3.18.2 PKU Testing

Newborn screening kits (PKU) are a covered benefit of the Idaho Medicaid Program. Test kits are ordered through the Idaho Newborn Screening Program and must be purchased in advance from:

Idaho Newborn Screening Program
450 West State Street, 4th floor
PO Box 83720
Boise, ID 83720-0036
(208) 334-4927 in the Boise calling area

3.18.3 Collection Fees

Collection of a lab specimen for a participant is not payable in an office setting.

3.18.4 Allergy Injections

Office calls are included in the reimbursement for allergy injections.

3.18.5 Immunizations

Most vaccines provided come through the Vaccines for Children (VFC) Program from the Department of Health and Welfare's Division of Health. Vaccine administration should conform to the Advisory Committee on Immunization Practices (ACIP) guidelines for vaccine use.

When billing for a participant who has both private insurance and Medicaid, bill the private insurance first using its billing instructions. After receiving the EOB from the primary insurance indicating partial or no payment, submit the EOB with the claim to Medicaid using the instructions below.

Medicaid should be billed for the administration of state-supplied vaccines according to the service(s) rendered at the time the vaccine was administered. Medicaid uses the most current version of the CPT guidelines.

Providers should bill their usual and customary rate for administration of vaccines, provider-purchased vaccines, and E/M services.

3.18.5.1 State-Supplied Free Vaccines

DHW offers a free-vaccine program for children who have not reached their 19th birthday. When a free vaccine(s) is administered, the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine with modifier **SL** billed at a zero dollar amount ($0.00).
- The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s).

3.18.5.2 Administration of State-Supplied Free Vaccine with Evaluation and Management (E/M) Visit

If there is a significant, separately identifiable service, performed, at the time of the vaccine administration, an E/M visit may also be billed, and the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine with modifier **SL** billed at a zero dollar amount ($0.00).

- The CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s).
- The appropriate CPT code for the E/M visit with modifier **25**.

  Note: In order to bill the E/M code, documentation in the participant's record must reflect that additional services were rendered at the time the vaccine was given.

3.18.5.3 Administration of a Provider Purchased Childhood Vaccine With or Without an Evaluation and Management (E/M) Visit

This should only occur when a free vaccine is not available. Services provided should be billed at the UCR. When a provider-purchased childhood vaccine is administered to a child less than 19 years old, the Medicaid claim must include the following information:

- The appropriate CPT or 5-digit HCPCS code for the injectable vaccine.
- The appropriate CPT code in the range of **90465** to **90474** that accurately reflects the administration of the vaccine(s).
- If there is a significant, separately identifiable service, performed, at the time of the vaccine administration, an appropriate E/M code may also be billed with modifier **25**.

  Note: In order to bill the E/M code, documentation in the participant's record must reflect that a significant, separately identifiable service was rendered at the time the vaccine was given.

See *Section 1.6.4 EPSDT Screening and Immunization Schedule*, for the complete schedule of age-appropriate health history and health screening services.

3.18.5.4 Administration of a Provider Purchased Adult Vaccine With or Without an Evaluation and Management (E/M) Visit

When an injection or adult vaccine is administered the Medicaid claim must include the following information:

- The appropriate CPT code for the vaccine(s) without a modifier.
- The CPT code in the range of **90471** to **90474** that accurately reflects the administration of the vaccine.
- If applicable, the appropriate CPT code for the E/M visit with modifier **25**.

  Note: In order to bill the E/M code, documentation in the participant's record must reflect that a significant, separately identifiable service was rendered at the time the vaccine was given.

3.18.5.5 Administration of an Injection that is Part of a Procedure

When an injection is administered that is part of a procedure (i.e., allergy injections, therapeutic, and diagnostic radiology, etc.), Medicaid will not pay the administration fee(s).

3.18.5.6 Administration Only of an Injectable/ Vaccine to a Participant with Medicare or Other Primary Payer and Medicaid

When billing for a participant who has either Medicare or private insurance, and Medicaid, bill Medicare/private insurance first using its billing instructions. If Medicare or the other primary payer combines payment for the administration with the cost of the injectable, a separate administration fee may not be charged.

3.18.6 Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. These outpatient services are limited to participants and providers who meet the criteria specifically identified in the *IDAPA 16.03.09.640-645 Medicaid Basic Plan Benefits* online at:
http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf

Providers must operate an American Diabetes Association (ADA) Recognized Diabetes Education Program to provide group diabetes counseling/training. Only Certified Diabetes Educators (CDE) may provide individual counseling through a recognized program, a physician's office, or outpatient hospital counseling. The billing provider must submit and maintain proof of the CDE's current diabetic counseling certification with EDS provider enrollment. Counseling services must be billed under the provider number of their employer (i.e. the hospital, or physician's clinic provider number).

3.18.6.1 Individual Counseling

To bill these services, use procedure code **G0108**, and bill in 30 minute increments, to comply with standard coding requirements. Individual counseling services must be face-to-face services between a CDE and the participant. The CDEs services are to augment and not a substitute for the services a physician is expected to provide to diabetic participants. Medicaid allows 12 hours, per participant every five years for individual counseling.

3.18.6.2 Group Counseling

Group counseling is billed with procedure code **G0109** and is billed in 30 minute increments to comply with standard coding requirements. Only hospitals operating an ADA recognized program may bill for group counseling. Medicaid allows 24 hours, per participant, every five years for this service.

3.18.6.3 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each HCPCS medication. This requirement applies to cancer drugs with HCPCS codes, claims submitted electronically and on the paper CMS-1500 claim form. This requirement does not apply to Medicare claims which crossover to Medicaid as the secondary payer.

The HCPCS medications that require NDC information are listed in the current *HCPCS Manual, Appendix 3*, alphabetically by both generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with EOB **628,** NDC Required.

The collection of the NDC information is now a federal requirement, and will allow Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho's Medicaid Program

Electronic Claims: For professional providers that use the PES billing software provided by EDS, HIPAA compliant fields to report the NDC information are available. Providers who are not set up to bill electronically with PES software may contact an EDS provider services representative for more information at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

To enter NDC data in the PES software, complete the Service and RX Tab fields using the following guidelines:

Service Tabs:

- Complete Service Tabs 1 and 2 as appropriate.
- Select Service Tab 3 and complete the appropriate fields.
- Enter Y in the RX Ind field to open the RX tab.

RX Tab:

Complete the following fields:

- NDC: Enter the 11-digit NDC number.
- Prescription Number: Not required.

- Units: Enter the units dispensed. Refer to the *Healthcare Common Procedure Coding System (HCPCS) Manual, Appendix 3*, for brief directions regarding the, Amount (Unit) column.
- Basis of Measurement: Enter IU (International Units), GR (Grams), ML (Milliliters), or UN (Units).
- Unit Price: Enter the price for the HCPCS medication dispensed.

Refer to the *Provider Electronic Solution (PES) Handbook, Section 9 (837 Professional Forms)* for more information on completing the Rx fields. It is available on the *Idaho Medicaid Provider Resources CD*.

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

Paper Claims: Submission of an NDC Detail Attachment is required with paper claim forms when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the NDC Detail Attachment is available in the *Appendix D; Forms* and can be used as a master copy.

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

3.19 Claim Billing

3.19.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year, (365 days) of the date of service.

3.19.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2 General Billing*, for more information.

3.19.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's nine 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transactions.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transactions.

National Drug Code (NDC) information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes,* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.19.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example*:* July 4, 2006 is entered as 07042006

3.19.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC or NDC Detail Attachment must be filled out and sent with the claim.

3.19.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:
EDS
PO Box 23
Boise, ID 83707

3.19.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field. The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

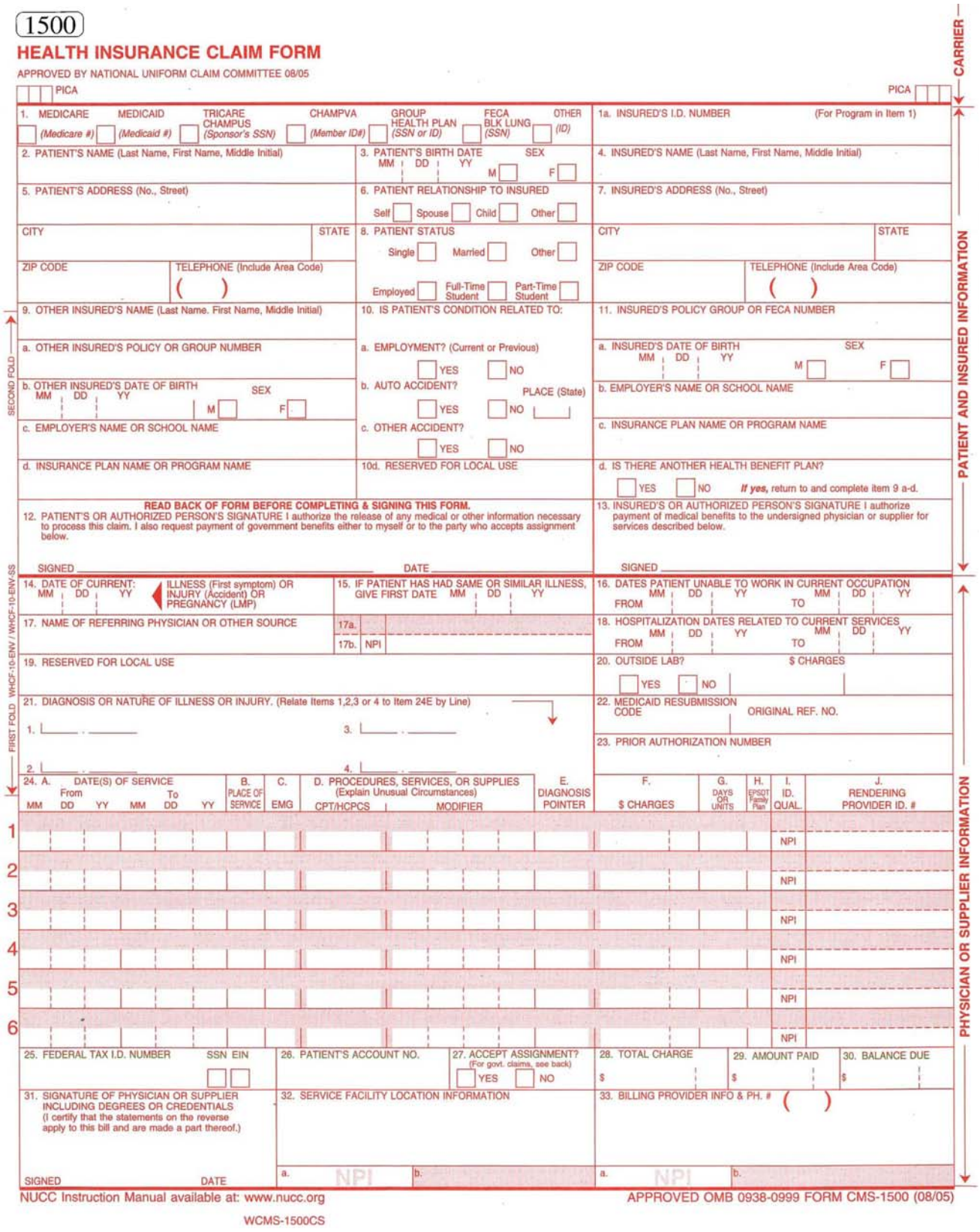
Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient's Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient's Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient's Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current: Illness, Injury, or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the year. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4 for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (1 - 4) for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qual.	Required, if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credential	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.
33	Billing Provider Info & Phone #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or Remittance Advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.

Field	Field Name	Use	Directions
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.19.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS